Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BEAUMONT BONE AND JOINT INSTITUTE
3650 LAUREL AVENUE
BEAUMONT TX 77707

Respondent Name
State Office of Risk Management

Carrier's Austin Representative
Box Number 45

MFDR Tracking Number
M4- 14-0719-01

MFDR Date Received
October 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Request for an itemized statement – Is an incorrect denial we are an Outpatient Surgical Center. According to TAC guidelines we have billed appropriately."

Amount in Dispute: $3,520.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…we will maintain our denial fro 16-Claim/Service lacks information which is needed for adjudication and 226-Information requested from the billing/rendering provider was not provided or was insufficient and/or incomplete."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 19, 2013	64721	$3,520.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. 28 Texas Administrative Code §133.210 sets out requirements of medical documentation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - 226 – INFORMATION REQUESTED FROM THE BILLING/RENDERING PROVIDER WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE.
   - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.

Issues

1. Did the requestor comply with documentation requirements?
2. Is respondent's denial supported?

Findings

1. 28 Texas Administrative Code §133.210 in pertinent part states, "…medical bills for the following services shall include the following supporting documentation: (5) for hospital services: an itemized statement of charges." Review of submitted bill and documentation finds type of bill 131 (Hospital, Outpatient, Admit thru Discharge Claim) however, no itemized statement was found. Therefore, the Division finds requirements of TAC §133.210 not met.
2. The respondent's denial reason is supported. No reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 10, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.